TRI-STATE MOBILE X-RAY

4684 CLAIRTON BOULEVARD
PITTSBURGH, PA 15236
412 • 881 • 9333
412 • 881 • 3522 (FAX)

Case No.
1:10-bk-05235 MDF

July 6, 2010

On the weekend of May 15, 2010 and thru Sunday May 17, 2010, The Residence for Renal Care called our answering service at (412) 881-9333, (answering service dispatch attached) and ordered "STAT" exams on four of their patients. Since a STAT exam is life threatening the x-ray tech on duty responded immediately and performed the exams. The x-rays were sent to our group of board certified radiologists and were read immediately and the results of the x-rays were provided to the facility.

The facility is refusing to pay us for our services. We are seeking reimbursement for services rendered.

Their argument is "That as a non-contracted provider, we should not have responded."

We believe that since they initiated contact and called our business number, ordered the exam, called back multiple times, let our x-ray techs in to the facility, (our employees wear ID badges), gave our x-ray techs the patients private health information, including social security numbers, dates of birth, etc. accepted the multiple x-ray reports with our company logo clearly displayed, there was no denying what company they were dealing with.

We have been in business in Whitehall for 30 years and when an exam is requested, especially a "STAT" life-threatening exam, we respond and perform that exam, which is our normal procedure. Patient health care is our main concern. In 30 years we have never encountered a facility refusing to reimburse us. Patient care is primary.

Sincerely,

Jack Stasik, Owner
Christine Mursch, General Manager
Christine Mursch

STATEMENT

ACCOUNT NO. 1005CRC

PAGE 1

Tri-State Mobile X-ray, Inc.

4684 Clairton Blvd
Pittsburgh, PA 15236
Phone: (412) 881-9333 Fax: (412) 881-3522

CHARGES OR PAYMENTS AFTER BILLING DATE 5/18/2010 WILL APPEAR ON YOUR NEXT STATEMENT

Bill To:
Residence for Renal Care
5511 Baum Blvd
Pittsburgh, PA 15232

AMOUNT ENCLOSED

CHARGES ARE DUE ON PRESENTATION OF THIS STATEMENT.
PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE.

PLEASE KEEP THIS PORTION FOR YOUR RECORDS

DATE	DESCRIPTION OF SERVICES	REFERENCE	CHARGES	CREDITS
5/18/2010	**100% Medicare Fee Schedule**	May-10	**$571.34**	

Amount Due $ **571.34**

Due Date **5/25/2010**

If you have questions please call: **(412) 881-3321 Billing Dept.**

STATEMENT

ACCOUNT NO. 93562

PAGE 1

Tri-State Mobile X-ray, Inc.

4684 Clairton Blvd
Pittsburgh, PA 15236
Phone: (412) 881-9333 Fax: (412) 881-3522

CHARGES OR PAYMENTS AFTER BILLING DATE 05/18/10 WILL APPEAR ON YOUR NEXT STATEMENT

Bill To:

Residence for Renal Care
5511 Baum Blvd
Pittsburgh, PA 15232

AMOUNT ENCLOSED

CHARGES ARE DUE ON PRESENTATION OF THIS STATEMENT.
PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE.

PLEASE KEEP THIS PORTION FOR YOUR RECORDS

DATE	DESCRIPTION OF SERVICES	REFERENCE	CHARGES	CREDITS
5/18/2010	Professional Reading Fee			
	Sandra Adams — Chest X-ray		$13.00	
	George Sullenberger — Abdomen X-ray		$13.00	
	Shirley Abrams — Chest X-ray		$13.00	

Amount Due **$39.00**

Due Date **5/25/2010**

If you have questions please call: **(412) 881-3321 Billing Dept.**

PART A / PPS BILLING
FOR FACILITY REFERENCE ONLY
DO NOT SUBMIT TO INS,

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 200429635

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ADAMS, SANDRA

3. PATIENT'S BIRTH DATE MM DD YY: 12 04 1951 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ADAMS, SANDRA

5. PATIENT'S ADDRESS (No., Street): 5511 BAUM BLVD

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 5511 BAUM BLVD

CITY: PITTSBURGH STATE: PA

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY: PITTSBURGH STATE: PA

ZIP CODE: 15232 TELEPHONE (Include Area Code): (412) 661 1740

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 15232 TELEPHONE (Include Area Code): (412) 661 1740

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 12 04 1951 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: PART A / PPS BILLING

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 5/17/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on File

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: UMESH GOLANI

17a.

17b. NPI 1033150412

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 518.3 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 15 10	05 15 10	31		71010	TC	1	13.07	1		NPI	1487826152
2 05 15 10	05 15 10	31		20092		1	16.75	1		NPI	1487826152
3 05 15 10	05 15 10	31		R0070		1	160.18	1		NPI	1487826152
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 251413903 [X]

26. PATIENT'S ACCOUNT NO.: ADASA001

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 190.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 190.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

TRI-STATE MOBILE X-RAY

SIGNED 5/17/2010 DATE

32. SERVICE FACILITY LOCATION INFORMATION

RESIDENCE FOR RENAL CARE
5511 BAUM BLVD
PITTSBURGH, PA 15232

a. b.

33. BILLING PROVIDER INFO & PH # ( )

TRI-STATE MOBILE X-RAY
4684 CLAIRTON BLVD
PITTSBURGH, PA 15236

a. 1487826152 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Mfd. by Medical Arts Press #14130 Medical Arts Press

Call toll-free: 1-800-328-2179

Use with Envelope #14145 (gummed) or #14146 (self-seal)

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PART A / PPS BILLING
FOR FACILITY REFERENCE ONLY
DO NOT SUBMIT TO INS,

PICA

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 176364057

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SULLENBERGER, GEORGE

3. PATIENT'S BIRTH DATE MM DD YY: 04 13 1947 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): SULLENBERGER, GEORGE

5. PATIENT'S ADDRESS (No., Street): 5511 BAUM BLVD

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 5511 BAUM BLVD

CITY: PITTSBURGH | STATE: PA

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY: PITTSBURGH | STATE: PA

ZIP CODE: 15232 | TELEPHONE (Include Area Code): (412) 661 1740

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 15232 | TELEPHONE (Include Area Code): (412) 661 1740

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 04 13 1947 SEX M [X] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: PART A / PPS BILLING

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE 5/17/2010

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED Signature on File

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DAVID BRILLMAN

17a.

17b. NPI 1386617132

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 560.1 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 16 10	05 16 10	31		74000	TC	1	14.41	1		NPI	1487826152
2 05 16 10	05 16 10	31		20092		1	16.75	1		NPI	1487826152
3 05 16 10	05 16 10	31		R0070		1	160.18	1		NPI	1487826152
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: 251413903 SSN [ ] EIN [X]

26. PATIENT'S ACCOUNT NO.: SULGE001

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 191.34

29. AMOUNT PAID: $

30. BALANCE DUE: $ 191.34

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

TRI-STATE MOBILE X-RAY

SIGNED 5/17/2010 DATE

32. SERVICE FACILITY LOCATION INFORMATION

RESIDENCE FOR RENAL CARE
5511 BAUM BLVD
PITTSBURGH, PA 15232

a. b.

33. BILLING PROVIDER INFO & PH # ( )

TRI-STATE MOBILE X-RAY
4684 CLAIRTON BLVD
PITTSBURGH, PA 15236

a. 1487826152 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

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FOR FACILITY REFERENCE ONLY
DO NOT SUBMIT TO INS,

PICA

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER [X] (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 183287629A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ABRAMS, SHIRLEY

3. PATIENT'S BIRTH DATE MM DD YY: 02 28 1935 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): ABRAMS, SHIRLEY

5. PATIENT'S ADDRESS (No., Street): 5511 BAUM BLVD

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 5511 BAUM BLVD

CITY: PITTSBURGH | STATE: PA

8. PATIENT STATUS: Single [ ] Married [ ] Other [X]

CITY: PITTSBURGH | STATE: PA

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Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: 15232 | TELEPHONE (Include Area Code): (412) 661 1740

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 02 28 1935 SEX M [ ] F [X]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: PART A / PPS BILLING

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

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SIGNED Signature on File

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15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: ABDUL KHAN

17a.

17b. NPI 1053349480

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 514 3. 2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 05 17 10	05 17 10	31		71010 TC		1	13.07	1		NPI	1487826152
2 05 17 10	05 17 10	31		00092		1	16.75	1		NPI	1487826152
3 05 17 10	05 17 10	31		R0070		1	160.18	1		NPI	1487826152
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 251413903

26. PATIENT'S ACCOUNT NO.: ABRSH000

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 190.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 190.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

TRI-STATE MOBILE X-RAY

SIGNED 5/17/2010 DATE

32. SERVICE FACILITY LOCATION INFORMATION

RESIDENCE FOR RENAL CARE
5511 BAUM BLVD
PITTSBURGH, PA 15232

a. b.

33. BILLING PROVIDER INFO & PH # ( )

TRI-STATE MOBILE X-RAY
4684 CLAIRTON BLVD
PITTSBURGH, PA 15236

a. 1487826152 b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

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May 17, 2010

Residence for Renal Care
551 Baum Blvd
Pittsburgh, PA 15232

ATTN: Administrator

Dear Mr. Nealon,

Enclosed is an invoice for services rendered to your patients by Tri-State Mobile X-ray, Inc. Your staff called our answering service over the weekend and ordered the enclosed exams and these exams were ordered as Stats. Our technologists did the exams that they were dispatched to do as STAT exams, because we are legally obligated to respond to any medical emergency, had our staff not responded and the patient suffered a medical malady, a potential disciplinary action could have been imposed against both of our organizations. Litigation could have been brought against both of our companies for failure to respond.

In light of the fact that we are not a contracted vendor, the enclosed invoices are the responsibility of your facility since the patients are Part A residents and we are unable to bill Medicare for these exams. The residence for Renal Care contacted our company and this error lies within your staff and their lack of knowledge with whom they are to call for exams. We respectfully submit these invoices for payment in the hopes of your full cooperation in reimbursing us for the services we rendered as our complete obligation to respond to your emergency call to our company. You are being charged 100% of the Medicare fee schedule as that is the legal amount that is required we bill as a non contractual service provider. There was one exam that was a medical assistance resident and we will bill this exam to the insurance carrier.

If you have any questions, please contact myself, the General Manager at (412) 881-7255. Thanking you for your attention to this most important matter.

Sincerely,

Christine Mursch, General Manger
Tri-State Mobile X-ray, Inc

Pennsylvania Dept. of State

Carefirst DBA / Residence for Renal Care
Management, LLC

3 copies

June 9, 2010

Residence for Renal Care
5511 Baum Blvd
Pittsburgh, PA 15232

Personal and Confidential

ATTN: Administrator

Dear Mr. Nealon,

I m sending this follow up letter to my original correspondence sent on May 17, 2010. We have not received your payment for the exams that Tri-State Mobile X-ray promptly performed on your patients at your staff's request.

This is a very serious matter and your response is requested immediately, a phone call will suffice to make arrangements to pay your statement. If payment and/or a response are not received within 14 days, further action will be pursued.

If you have any questions, please contact myself, the General Manager at (412) 881-7255. Thanking you for your attention to this most important matter.

Sincerely,

Christine Mursch, General Manger
Tri-State Mobile X-ray, Inc

CC: Barbara Milillo, TSMX President

UNITED STATES POSTAL SERVICE®

< Back Print

Printed Domestic Labels

Transaction #: 170570326
Charged to: MC **********4307
Labels Included: 1
Print Date/Time: 6/9/10 10:38:46 AM CDT

	Delivery Address	Package Info	Service	Price
1 of 1	RESIDENCE FOR RENAL 5511 BAUM BLVD PITTSBURGH, PA 15232-1203	Ship Date: 06/09/10 Weight: 0lbs 6oz From: 15236	Priority Mail Signature Confirm. **Label Total**	$4.80 $1.95 **$6.75**

Signature Confirmation™ Label Number: **9410 8036 9930 0008 0670 21**

Domestic Order Total: $6.75

IF FOR ARM/LEG ASK WHAT PART IT IS
IS FOR WHOLE ARM OR LEG?:
SYMPTOM:
INSURANCE:
ASK IF THE INSURANCE IS AN HMO:
MEDICARE#(MUST ASK): - -
IF THEY DO NOT KNOW DO NOT PRESS
D O B:
REQUESTING DR:
WAS REQUISITION FAXED:
==========
Sun 16-May-10 08:34p KB TAKEN
Sun 16-May-10 09:08p LK DELIVERED
GIVEN TO:
WHEN NEEDED?:ASAP (WHEN YOU COME?)
NAME:BOB
FACILITY:RESIDENCE FOR RENAL CARE
TEL#: (412)661-1740
FAX#:(412)661-7866 AND 7029
PATIENT NAME:ADAMS, SANDRA
RM#:2091 UNIT:2ND FL
TYPE OF X-RAY:CHEST
(IF CHEST ASK IF AP/LATERAL/OR/BOTH)!!
(DO.NOT.PUT.REGULAR):BOTH
IF FOR ARM/LEG ASK WHAT PART IT IS
IS FOR WHOLE ARM OR LEG?:
SYMPTOM:POST ANTIBIOTIC TREATMENT
INSURANCE:BL CROSS BL SHIELD
ASK IF THE INSURANCE IS AN HMO:
MEDICARE#(MUST ASK): - -
IF THEY DO NOT KNOW DO NOT PRESS
D O B:12/04/51
REQUESTING DR:KHAN
WAS REQUISITION FAXED:
Dialout history
Sun 16-May-10 09:05p LK Dialout
4127798305
==========
Sun 16-May-10 08:34p KB TAKEN
Sun 16-May-10 09:07p LK DELIVERED
GIVEN TO:
WHEN NEEDED?:STAT
NAME:BOB
FACILITY:RESIDENCE FOR RENAL CARE
TEL#: (412)661-1740
FAX#:(412)661-7866 AND 7029
PATIENT NAME:POPP, DEBRA
RM#:1062 UNIT:1ST FL
TYPE OF X-RAY:UPPER RIGHT CHEST
CATHETER
(IF CHEST ASK IF AP/LATERAL/OR/BOTH)!!
(DO.NOT.PUT.REGULAR):
IF FOR ARM/LEG ASK WHAT PART IT IS
IS FOR WHOLE ARM OR LEG?:
SYMPTOM:DISLODGEMENT OF DIALYSIS CATH

Done

Done

INSURANCE:MEDICAID
ASK IF THE INSURANCE IS AN HMO:
MEDICARE#(MUST ASK): - -
IF THEY DO NOT KNOW DO NOT PRESS
D O B:12/14/55
REQUESTING DR:LAWLOR
WAS REQUISITION FAXED:
Dialout history
Sun 16-May-10 08:36p MGE Dialout
4128124601
Sun 16-May-10 08:36p MGE Dialout
7247474970
Sun 16-May-10 08:36p MGE Dialout
4129490131
Sun 16-May-10 08:37p MGE Dialout
4129191500#
Sun 16-May-10 08:52p MGE Dialout
4128124601
==========
Sun 16-May-10 01:58p DG TAKEN
Sun 16-May-10 02:02p SF DELIVERED
GIVEN TO:MIKE RECD
WHEN NEEDED?:TODAY
NAME:KATHLEEN
FACILITY:KANE - MCKEESPORT
TEL#: (412)675-8743
FAX#:( ) -
PATIENT NAME:FRANK SCALESE
RM#:334W UNIT:3B
TYPE OF X-RAY:CHEST
(IF CHEST ASK IF AP/LATERAL/OR/BOTH)!!
(DO.NOT.PUT.REGULAR):BOTH
IF FOR ARM/LEG ASK WHAT PART IT IS
IS FOR WHOLE ARM OR LEG?:
SYMPTOM:INCREASED COUGH/CONGESTION
INSURANCE:MEDICARE
ASK IF THE INSURANCE IS AN HMO:
MEDICARE#(MUST ASK):190-03-8286A
IF THEY DO NOT KNOW DO NOT PRESS
D O B:1-29-14
REQUESTING DR:REYES
WAS REQUISITION FAXED:
Dialout history
Sun 16-May-10 02:04p LAM Dialout
4128124601
==========
Sun 16-May-10 01:56p CLE TAKEN
Sun 16-May-10 02:01p SF DELIVERED
REQUEST FOR RESULTS!
NAME OF CALLER?:KATHY TAYLOR
FACILITY?:KANE MIKE RECD
LOCATION:MCKEES PORT
TEL#: (412)675-8747
EXTENSION(IF ANY):NONE
PATIENT'S NAME:KATHLEEN VAZQUEZ

ROOM#:449D UNIT:4A
WHAT TEST DID PT HAVE & WHEN WAS IT
DONE?:LS SPINE 05/14/10
DR REQUESTING?:REYES
IF FOR ARM/LEG ASK WHAT PART IT IS
IS FOR WHOLE ARM OR LEG?:
SYMPTOM:PAIN
INSURANCE:UMPC FOR YOU
ASK IF THE INSURANCE IS AN HMO:YES
MEDICARE#(MUST ASK):NON-E -
IF THEY DO NOT KNOW DO NOT PRESS
D O B:12/05/46
REQUESTING DR:REYES
WAS REQUISITION FAXED:NO
------- 05/16/2010 01:58p CLE --------
TRIED TO PATCH PER CLIENT INFO BUT ANS
==========
Sun 16-May-10 11:30a SH TAKEN
Sun 16-May-10 11:38a CLE DELIVERED
GIVEN TO:LFT MSG ON VC/M TO CALL TAs
WHEN NEEDED?:TODAY
NAME:KATHY
FACILITY:KANE MCKEESPORT
TEL#: (412)675-8747
FAX#:( ) -
PATIENT NAME:PATTY MELEGARI
RM#:450 D UNIT:4 A
TYPE OF X-RAY:FLAT PLATE OF ABDOMEN
(IF CHEST ASK IF AP/LATERAL/OR/BOTH)!!
(DO.NOT.PUT.REGULAR):
IF FOR ARM/LEG ASK WHAT PART IT IS
IS FOR WHOLE ARM OR LEG?:
SYMPTOM:CONSTIPATED
INSURANCE:MEDCICARE
ASK IF THE INSURANCE IS AN HMO:
MEDICARE#(MUST ASK): - -
IF THEY DO NOT KNOW DO NOT PRESS
D O B:7/30/44
REQUESTING DR:REYES
WAS REQUISITION FAXED:------- 05/16/20
MIKE RECEIVED
Dialout history
Sun 16-May-10 11:32a SH Dialout
4128124601
==========
Sun 16-May-10 10:38a LAM TAKEN
Sun 16-May-10 10:42a LAM DELIVERED
GIVEN TO:MIKE
WHEN NEEDED?:ASAP
NAME:AYONA WILLIAMS
FACILITY:RESIDENCE IN RENAL CARE
TEL#: (412)661-1740
FAX#:(412)661-7029
PATIENT NAME:SULLENBERGER, GEORGE
RM#:211 UNIT:2ND FLOOR

TYPE OF X-RAY:FLAT PLATE
(IF CHEST ASK IF AP/LATERAL/OR/BOTH)!!
(DO.NOT.PUT.REGULAR):
IF FOR ARM/LEG ASK WHAT PART IT IS
IS FOR WHOLE ARM OR LEG?:
SYMPTOM:THREE LARGE EMESIS, VOMITING
INSURANCE:MEDICARE
ASK IF THE INSURANCE IS AN HMO:
MEDICARE#(MUST ASK):176-36-4057A
IF THEY DO NOT KNOW DO NOT PRESS
D O B:
REQUESTING DR:KHAN
WAS REQUISITION FAXED:NO
Dialout history
Sun 16-May-10 10:41a LAM Dialout
4128124601
==========
Sun 16-May-10 08:26p TE TAKEN
Sun 16-May-10 09:10p LK DELIVERED
GIVEN TO:WOMAN REFUSED MESSAGE
WHEN NEEDED?:
NAME:
FACILITY:
TEL#: ( ) -
FAX#:( ) -
PATIENT NAME:
RM#: UNIT:
TYPE OF X-RAY:
(IF CHEST ASK IF AP/LATERAL/OR/BOTH)!!
(DO.NOT.PUT.REGULAR):
IF FOR ARM/LEG ASK WHAT PART IT IS
IS FOR WHOLE ARM OR LEG?:
SYMPTOM:
INSURANCE:
ASK IF THE INSURANCE IS AN HMO:
MEDICARE#(MUST ASK): - -
IF THEY DO NOT KNOW DO NOT PRESS
D O B:
REQUESTING DR:
WAS REQUISITION FAXED:

PLEASE PRINT

Insurance Requires Your Full Name
Last Name / Middle Initial / First Name

PATIENT NAME Popp (Last) Debra (Middle First)

ADDRESS

CALL REPORTS TO #

NURSING HOME Res for Renal Care

M/CARE # ☐☐☐ ☐☐ ☐☐☐☐ ☐ LETTERS

MED. ASSISTANCE

OTHER INS. NAME

INS. ID # GROUP #

APPROVAL ☐ YES ☐ NO Approval #

☐ Nursing Home 412-661-1740 PHONE NUMBER

☐ Patients Residence PHONE NUMBER

SIGN HERE SIGNATURE PATIENT

TRI-STATE MOBILE X-RAY

PHONE: 412•881•9333
FAX: 412•881•3522
IF NO PHONE SERVICE: 724•746•6099

Prepared by:

D.O.B. 12/14/55 Rm # Unit #

Male ☐ Female ☐

SS# 203 52 4192

RESPONSIBLE PARTY INFORMATION REQUIRED.

Name

Address

City

State Zip

WITNESS'S SIGNATURE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Tri-State Mobile X-Ray, Inc., for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

CHECK ☐ FOR EXAM DESIRED CIRCLE RIGHT OR LEFT	FOR OFFICE USE ONLY VIEWS				CHECK ☐ FOR EXAM DESIRED CIRCLE RIGHT OR LEFT			FOR OFFICE USE ONLY VIEWS		
SPINE:					**EXTREMITIES:**					
☐ LUMBAR	AP	LAT	OBLIQ		☐ SHOULDER	R	L	INT	EXT	OBLIQ
☐ CERVICAL	AP	LAT	OBLIQ		☐ CLAVICLE	R	L	INT	EXT	OBLIQ
☐ DORSAL	AP	LAT	OBLIQ		☐ HUMERUS	R	L	AP	LAT	OBLIQ
☐ COCCYX	AP	LAT	OBLIQ		☐ ELBOW	R	L	AP	LAT	OBLIQ
THORAX:					☐ FOREARM	R	L	AP	LAT	OBLIQ
X CHEST	(AP)	LAT	OBLIQ		☐ WRIST	R	L	AP	LAT	OBLIQ
☐ RIBS R L	AP	LAT	OBLIQ		☐ HAND	R	L	AP	LAT	OBLIQ
☐ STERNUM	AP	LAT	OBLIQ		☐ FINGERS	R	L	AP	LAT	OBLIQ
ABDOMEN:					☐ PELVIS	R	L	AP		
☐ PLAIN FILM	AP				☐ HIP	R	L	AP	LAT	OBLIQ
☐ ABDOMINAL SERIES	AP	LAT	OBLIQ		☐ FEMUR	R	L	AP	LAT	OBLIQ
☐ SKULL	AP	LAT	OBLIQ		☐ KNEE	R	L	AP	LAT	OBLIQ
☐ NASAL BONES	AP	LAT	OBLIQ		☐ LOWER LEG	R	L	AP	LAT	OBLIQ
☐ FACIAL BONES	AP	LAT	OBLIQ		☐ ANKLE	R	L	AP	LAT	OBLIQ
☐ SINUS	AP	LAT	OBLIQ	WATERS	☐ FOOT	R	L	AP	LAT	OBLIQ
					☐ TOES	R	L	AP	LAT	OBLIQ

A Portable Exam is being ordered because, due to age and physical condition, patient is confined to this facility.

☐ HOLTER MONITOR* ☐ EKG HT. WT.

* Lost or damaged equipment will be the responsibility of the patient.

Does the patient have reason to believe she is pregnant? ☐ Yes ☐ No

Protective Shielding Used? ☐ Yes ☐ No

Date Completed 5/15/10

Technician

PHYSICIAN'S SIGNATURE V/O

FIRST NAME LAST NAME Golani

ADDRESS

PHONE

Symptoms of Patient (Dr. ordering exam please initial)

Correction to MA #

RESIDENCE FOR RENAL CARE

ADMISSION RECORD

RESIDENT INFORMATION

Medical Record#	Last Name	First Name	MI	Social Security#	Room #	Original Admit Date	Current Admit Date
1288	POPP	DEBRA	A	203-52-4192	109	10/15/2009	10/15/2009

DOB	Age	Gender	Race	Marital Status	Veteran	Religion	Church Affiliation	Advanced Directive
12/14/1955	54	F	WHITE,	MARRIED	UNK	CATHOLIC		

Last Permanent Address:
47 MATTHEWS ROAD
BELLE VERNON, PA 15012

Power Of Attorney

Medical
Name:
Rel.ship:
Phone:

Financial
Name:
Rel.ship:
Phone:

PHYSICIAN INFORMATION

Attending Physician	Telephone Number	Pager #	Office FAX #
DR. UMESH GOLANI	1-412-784-7020		1-412-784-7025

Consulting Physician	Telephone Number	Pager #	Office FAX #
MAUREEN LAWLOR	1-412-232-8688		1-412-242-8863

INSURANCE INFORMATION

Medicare#	Medicare B	Medicaid #
		8001589426

Insurance Company - Address	Policy # or Group ID number		
	8001589426	Contact Person	
		Phone Number	
		FAX Number	
Insurance Company - Address	**Policy # or Group ID number**	**Contact Person**	
UPMC FOR YOU	8001589426	Phone Number	
	000000	FAX Number	

Admitted From	Prior Hospitalization Dates	# of Medicare Days used	Level of Care
			INTERMEDIATE

EMERGENCY CONTACTS

Primary Emergency Contact	Alternate Contact # 2	Alternate Contact # 3
Contact name: POPP GARY	Contact name:	Contact name:
Relationship: SPOUSE	Relationship:	Relationship:
Street: 848 DONNER AVENUE	Street:	Street:
City/State: MONESSEN, PA	City/State:	City/Street:
Zip Code: 15062	Zip Code:	Zip Code:
Home Phone: 724-797-6208	Home Phone:	Home Phone:
Work Phone:	Work Phone:	Work Phone:
Cell Phone:	Cell Phone:	Cell Phone:

MISCELLANEOUS

Primary Pharmacy:
Phone:

Hospital Preference:
Phone : --

Funeral Home:
Phone :

Primary Diagnosis:
END STAGE RENAL DISEASE

ICD-9 Code: 585.6

Allergies :

Discharge Date:

Other Diagnosis:
ACUTE RESPIRATRY FAILURE — 518.81
HYPERTENSION NOS — 401.9

Discharge Time:

Discharge Destination:

TRI-STATE MOBILE X-RAY
4684 CLAIRTON BOULEVARD
PITTSBURGH, PA 15236
(412) 881-9333

Name: Popp Debra
Patient ID: 121-203524192
Date of Birth: 12/14/1955
Study: CR - Chest, PF Chest
Facility: Residence for Renal Care
Physician: Golani, Dr.
Date of Service: 05/15/2010 22:49:23

CLINICAL:
Catheter placement.

X-RAY EXAMINATION - CHEST

TECHNIQUE:
Single anterior-posterior view chest

COMPARISON:
None.

FINDINGS:
Normal visualized trachea and bronchi. There is elevation of the right hemidiaphragm. There is a right internal jugular dual lumen catheter with its tip extending into the superior vena cava/right heart.

Normal lungs.

Normal pleura.

Normal heart.

Normal pulmonary arteries.

Normal visualized aortic arch and descending thoracic aorta.

Normal mediastinum. Normal hilar regions.

Normal chest wall structures.

Normal osseous structures.

Unremarkable upper abdomen.

IMPRESSION:
No acute cardio pulmonary disease.
Right internal jugular dual lumen catheter as described above.

Signed:

Stephen Handler, M.D.
May 16th, 2010 at 11:20:09 PM EDT
Electronically Signed

SH/SH

As part of our Quality Assurance Program, we request that surgical or pathologic correlation, or any additional supportive or discordant medical history, laboratory or imaging studies be forwarded to Radisphere National Radiology Group, attention: Peer Review Coordinator. Phone 216.255.5796, Fax 866-788-0204, 23625 Commerce Park, Suite 204 Beachwood, OH 44122.

TRANSMISSION VERIFICATION REPORT

TIME : 05/16/2010 23:26
NAME : TRI STATE
FAX : 4128813522
TEL :
SER.# : BROG8J838359

DATE,TIME	05/16 23:25
FAX NO./NAME	14126617866
DURATION	00:00:44
PAGE(S)	02
RESULT	OK
MODE	STANDARD ECM

TRI-STATE MOBILE X-RAY
4684 CLAIRTON BOULEVARD
PITTSBURGH, PA 15236
(412) 881-9333

Name: Popp Debra
Patient ID: 121-203524192
Date of Birth: 12/14/1955
Study: CR - Chest, PF Chest
Facility: Residence for Renal Care
Physician: Golani, Dr.
Date of Service: 05/15/2010 22:49:23

CLINICAL:
Catheter placement.

X-RAY EXAMINATION - CHEST

TECHNIQUE:
Single anterior-posterior view chest

COMPARISON:
None

PLEASE PRINT

Insurance Requires Your Full Name
Last Name / Middle Initial / First Name

PATIENT NAME Adams (Last) Sandra (Middle / First)

ADDRESS

CALL REPORTS TO #

NURSING HOME Res for Renal Care

M/CARE # ☐☐☐ ☐☐ ☐☐☐☐ ☐ (LETTERS)

MED. ASSISTANCE

OTHER INS. NAME

INS. ID # GROUP #

APPROVAL ☐ YES ☐ NO Approval #

☐ Nursing Home PHONE NUMBER

☐ Patients Residence PHONE NUMBER

SIGN HERE SIGNATURE PATIENT

TRI-STATE MOBILE X-RAY

PHONE: 412•881•9333
FAX: 412•881•3522
IF NO PHONE SERVICE: 724•746•6099

Prepared by:

D.O.B 12/4/51 Rm # Unit #

Male ☐ Female ☐

SS# 200 42 9635

RESPONSIBLE PARTY INFORMATION REQUIRED.

Name

Address

City

State Zip

WITNESS'S SIGNATURE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Tri-State Mobile X-Ray, Inc., for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

CHECK ☐ FOR EXAM DESIRED CIRCLE RIGHT OR LEFT	FOR OFFICE USE ONLY VIEWS			
SPINE:				
☐ LUMBAR	AP	LAT	OBLIQ	
☐ CERVICAL	AP	LAT	OBLIQ	
☐ DORSAL	AP	LAT	OBLIQ	
☐ COCCYX	AP	LAT	OBLIQ	
THORAX:				
☒ CHEST	(AP)	LAT	OBLIQ	
☐ RIBS R L	AP	LAT	OBLIQ	
☐ STERNUM	AP	LAT	OBLIQ	
ABDOMEN:				
☐ PLAIN FILM	AP			
☐ ABDOMINAL SERIES	AP	LAT	OBLIQ	
☐ SKULL	AP	LAT	OBLIQ	
☐ NASAL BONES	AP	LAT	OBLIQ	
☐ FACIAL BONES	AP	LAT	OBLIQ	
☐ SINUS	AP	LAT	OBLIQ	
	AP	LAT	OBLIQ	WATERS

CHECK ☐ FOR EXAM DESIRED CIRCLE RIGHT OR LEFT			FOR OFFICE USE ONLY VIEWS		
EXTREMITIES:					
☐ SHOULDER	R	L	INT	EXT	OBLIQ
☐ CLAVICLE	R	L	INT	EXT	OBLIQ
☐ HUMERUS	R	L	AP	LAT	OBLIQ
☐ ELBOW	R	L	AP	LAT	OBLIQ
☐ FOREARM	R	L	AP	LAT	OBLIQ
☐ WRIST	R	L	AP	LAT	OBLIQ
☐ HAND	R	L	AP	LAT	OBLIQ
☐ FINGERS	R	L	AP	LAT	OBLIQ
☐ PELVIS	R	L	AP		
☐ HIP	R	L	AP	LAT	OBLIQ
☐ FEMUR	R	L	AP	LAT	OBLIQ
☐ KNEE	R	L	AP	LAT	OBLIQ
☐ LOWER LEG	R	L	AP	LAT	OBLIQ
☐ ANKLE	R	L	AP	LAT	OBLIQ
☐ FOOT	R	L	AP	LAT	OBLIQ
☐ TOES	R	L	AP	LAT	OBLIQ

A Portable Exam is being ordered because, due to age and physical condition, patient is confined to this facility.

☐ HOLTER MONITOR* ☐ EKG HT. WT.

* Lost or damaged equipment will be the responsibility of the patient.

PHYSICIAN'S SIGNATURE V/O

FIRST NAME LAST NAME Golani

ADDRESS

PHONE

Symptoms of Patient (Dr. ordering exam please initial)

Chest infection

Does the patient have reason to believe she is pregnant? ☐ Yes ☐ No

Protective Shielding Used? ☐ Yes ☐ No

Date Completed 5/15/10

Technician

Residence for Renal Care at Shadyside / Center for Renal Care at Shadyside

ADMITTING RECORD

Admission Time: 2:00

RESIDENT ADMISSION INFORMATION

Medical Record Number	Admitted From	Hospital Dates
1329	Life Care Hospital	2-9-2010 to 4-28-2010

Room/Bed	Original Admission Date	Previous Admission Date	Current Admission Date
209-1	4-28-2010	4-28-2010	4-28-2010

RESIDENT DEMOGRAPHIC INFORMATION

Resident Name	Social Security Number
Sandra L. Adams	200-42-9635

Address: 141 Jeannette Drive Verona, Pa 15147

Phone	Birthdate	Age
412-951-0428	12/4/1951	58

Citizen of Country	Religion Affiliation	Church Affiliation
USA	Baptist	

Gender	Marital Status	Race
Female	Divorced	Black

CONTACT INFORMATION

Emergency 1st Contact	Address	Home Phone	Other Phone	Relationship
Craig Adams		412-378-5284	412-242-0301	Son

Emergency 2nd Contact	Address	Home Phone	Other Phone	Relationship

PROVIDER INFORMATION

Physician/Primary/Attending	Phone	Fax
Dr. Abdul Khan	412-242-8860	

Nephrologist	Phone	Fax
To be determined		

Community Dialysis Center and Phone	Community Nephrologist
n/a	

Pharmacy	Allergies
St. Clair	No Heparin

Preferred Hospital: West Penn Hospital

Funeral Home:

DIAGNOSIS INFORMATION

Primary Diagnosis	Secondary Diagnosis	Tertiary Diagnosis
Respiratory Failure on Vent, ESRD	ESRD	Anemia

PAYER INFORMATION

Medicare Number	Medicare Part	Co-Insurance Name	Policy Number
	A ☐ B ☐		

HMO Name	Policy Number	Auth Number	Last Covered Day
Blue Cross/Blue Shield	ZAR104529836001	5450803-001	5/4/2010

Medicaid Number	Approved for NH	Needs Optioned
	Ye ☐ No ☐	Ye ☐ No ☐

TRI-STATE MOBILE X-RAY
4684 CLAIRTON BOULEVARD
PITTSBURGH, PA 15236
(412) 881-9333

Name: Adams Sandra
Patient ID: 121-200422010
Date of Birth: 12/04/1951
Study: CR - Chest, PF Chest
Facility: Residence for Renal Care
Physician: Golani, Dr.
Date of Service: 05/15/2010 22:44:39

CLINICAL:
Chest infection.

X-RAY EXAMINATION - CHEST

TECHNIQUE:
Single anterior-posterior view

COMPARISON:
None.

FINDINGS:
Normal visualized trachea and bronchi. The lungs are under expanded. There is a left-sided Port-A-Cath with the distal tip in the superior vena cava.

There is some diffuse increased interstitial changes throughout the right lung, which are suspicious for a diffuse interstitial pneumonitis.

Normal pleura.

There is cardiomegaly.

Normal pulmonary arteries.

Normal visualized aortic arch and descending thoracic aorta.

Normal mediastinum. Normal hilar regions.

Normal chest wall structures.

Status post lower cervical fusion implying orthopedic hardware.

Unremarkable upper abdomen.

IMPRESSION:
There is some diffuse interstitial disease throughout the right lung, consistent with pneumonitis.
Left-sided Port-A-Cath with the distal tip in the superior vena cava.
Cardiomegaly.

Signed:

Stephen Handler, M.D.
May 16th, 2010 at 11:18:22 PM EDT
Electronically Signed

SH/SH

As part of our Quality Assurance Program, we request that surgical or pathologic correlation, or any additional supportive or discordant medical history, laboratory or imaging studies be forwarded to Radisphere National Radiology Group, attention: Peer Review Coordinator. Phone 216.255.5796, Fax 866-788-0204, 23625 Commerce Park, Suite 204 Beachwood, OH 44122.

TRANSMISSION VERIFICATION REPORT

TIME : 05/16/2010 23:25
NAME : TRI STATE
FAX : 4128813522
TEL :
SER.# : BROG8J838359

DATE,TIME	05/16 23:24
FAX NO./NAME	14126617866
DURATION	00:00:46
PAGE(S)	02
RESULT	OK
MODE	STANDARD ECM

https://www.apexrad.com/records/report-download.php/9088715/trans...

TRI-STATE MOBILE X-RAY
4684 CLAIRTON BOULEVARD
PITTSBURGH, PA 15236
(412) 881-9333

Name: Adams Sandra
Patient ID: 121-200422010
Date of Birth: 12/04/1951
Study: CR - Chest, PF Chest
Facility: Residence for Renal Care
Physician: Golani, Dr.
Date of Service: 05/15/2010 22:44:39

CLINICAL:
Chest infection.

X-RAY EXAMINATION - CHEST

TECHNIQUE:
Single anterior-posterior view

COMPARISON:
None.

PLEASE PRINT

Insurance Requires Your Full Name
Last Name / Middle Initial / First Name

TRI-STATE MOBILE X-RAY

PHONE:
412•881•9333
FAX:
412•881•3522
IF NO PHONE SERVICE:
724•746•6099

PATIENT NAME Sullen Berger L. George
Last Middle First

ADDRESS

CALL REPORTS TO #

NURSING HOME Residence for Renal Care

Prepared by:

M/CARE # [ ][ ][ ] [ ][ ] [ ][ ][ ][ ] [A] LETTERS

D.O.B. 4/13/47 Rm # 211 Unit # 2ND FL

MED. ASSISTANCE A- 6-1-04

Male ☒ Female ☐

OTHER INS. NAME B= none

SS# 176 36 4057

INS. ID # GROUP #

RESPONSIBLE PARTY INFORMATION REQUIRED.

Name

APPROVAL ☐ YES ☐ NO Approval #

Address

☒ Nursing Home 412 661-8000 / ☐ Patient's Residence FAX 661-7029

City

PHONE NUMBER -1740 / PHONE NUMBER

State Zip

SIGN HERE

SIGNATURE PATIENT

WITNESS'S SIGNATURE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Tri-State Mobile X-Ray, Inc., for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

CHECK ☐ FOR EXAM DESIRED CIRCLE RIGHT OR LEFT			FOR OFFICE USE ONLY VIEWS		
SPINE:					
☐ LUMBAR			AP	LAT	OBLIQ
☐ CERVICAL			AP	LAT	OBLIQ
☐ DORSAL			AP	LAT	OBLIQ
☐ COCCYX			AP	LAT	OBLIQ
THORAX:					
☐ CHEST			AP	LAT	OBLIQ
☐ RIBS	R	L	AP	LAT	OBLIQ
☐ STERNUM			AP	LAT	OBLIQ
ABDOMEN:					
☒ PLAIN FILM			AP		
☐ ABDOMINAL SERIES			AP	LAT	OBLIQ
☐ SKULL			AP	LAT	OBLIQ
☐ NASAL BONES			AP	LAT	OBLIQ
☐ FACIAL BONES			AP	LAT	OBLIQ
☐ SINUS			AP	LAT	OBLIQ
			AP	LAT	OBLIQ WATERS

CHECK ☐ FOR EXAM DESIRED CIRCLE RIGHT OR LEFT			FOR OFFICE USE ONLY VIEWS		
EXTREMITIES:					
☐ SHOULDER	R	L	INT	EXT	OBLIQ
☐ CLAVICLE	R	L	INT	EXT	OBLIQ
☐ HUMERUS	R	L	AP	LAT	OBLIQ
☐ ELBOW	R	L	AP	LAT	OBLIQ
☐ FOREARM	R	L	AP	LAT	OBLIQ
☐ WRIST	R	L	AP	LAT	OBLIQ
☐ HAND	R	L	AP	LAT	OBLIQ
☐ FINGERS	R	L	AP	LAT	OBLIQ
☐ PELVIS	R	L	AP		
☐ HIP	R	L	AP	LAT	OBLIQ
☐ FEMUR	R	L	AP	LAT	OBLIQ
☐ KNEE	R	L	AP	LAT	OBLIQ
☐ LOWER LEG	R	L	AP	LAT	OBLIQ
☐ ANKLE	R	L	AP	LAT	OBLIQ
☐ FOOT	R	L	AP	LAT	OBLIQ
☐ TOES	R	L	AP	LAT	OBLIQ

A Portable Exam is being ordered because, due to age and physical condition, patient s confined to this facility.

☐ HOLTER MONITOR* ☐ EKG HT. WT.

* Lost or damaged equipment will be the responsibility of the patient.

PHYSICIAN'S SIGNATURE

FIRST NAME LAST NAME Brillman

ADDRESS

PHONE

Symptoms of Patient (Dr. ordering exam please initial)

History of Ileus

Does the patient have reason to believe she is pregnant? ☐ Yes ☐ No

Protective Shielding Used? ☐ Yes ☐ No

Date Completed 5-16-10

Technician MM

2ND FL Called Neuro 230p.

RESIDENCE FOR RENAL CARE

ADMISSION RECORD

RESIDENT INFORMATION

ical Record#	Last Name	First Name	MI	Social Security#	Room #	Original Admit Date	Current Admit Date
1316	SULLENBERGER	GEORGE	L	176-36-4057	211	03/24/2010	03/24/2010

DOB	Age	Gender	Race	Marital Status	Veteran	Religion	Church Affiliation	Advanced Directive
04/13/1947	62	M	WHITE,	DIVORCED	UNK	BAPTIST		

Last Permanent Address:
153 EAST FIRST AVENUE
DERRY, PA 15627

Power Of Attorney

Medical
Name:
Rel.ship:
Phone:

Financial
Name:
Rel.ship:
Phone:

PHYSICIAN INFORMATION

Attending Physician	Telephone Number	Pager #	Office FAX #
DAVID BRILLMAN	1-412-621-3593		

Consulting Physician	Telephone Number	Pager #	Office FAX #
MAUREEN LAWLOR	1-412-232-8688		1-412-242-8863

INSURANCE INFORMATION

Medicare#	Medicare B	Medicaid #
176364057A	-	-

Insurance Company - Address	Policy # or Group ID number	Contact Person	
	176364057A	Phone Number	
		FAX Number	

Admitted From	Prior Hospitalization Dates	# of Medicare Days used	Level of Care
LIFECARE HOSPITAL	12/09/2009-03/24/2010	7	SKILLED-NON M/C

EMERGENCY CONTACTS

Primary Emergency Contact	Alternate Contact # 2	Alternate Contact # 3
Contact name: SULLENBERGER JEFFREY	Contact name:	Contact name:
Relationship: SON	Relationship:	Relationship:
Street:	Street:	Street:
City/State: DERRY, PA	City/State:	City/Street:
Zip Code:	Zip Code:	Zip Code:
Home Phone: 724-863-2404	Home Phone:	Home Phone:
Work Phone: 724-961-1666	Work Phone:	Work Phone:
Cell Phone:	Cell Phone:	Cell Phone:

MISCELLANEOUS

Primary Pharmacy:	Hospital Preference:	Funeral Home:
Phone:	Phone : --	Phone :

Primary Diagnosis:	ICD-9 Code	Allergies :	Discharge Date:
END STAGE RENAL DISEASE	585.6	NKA	
Other Diagnosis:			Discharge Time:
ACUTE RESPIRATRY FAILURE	518.81		
SLEEP APNEA NOS	780.57		Discharge Destination:

TRI-STATE MOBILE X-RAY
4684 CLAIRTON BOULEVARD
PITTSBURGH, PA 15236
(412) 881-9333

Name: Sullenberger George
Patient ID: 121-176364057
Date of Birth: 04/13/1947
Study: CR - Abdomen, PF Abdomen
Facility: Scott Kane
Physician: Brillman, Dr.
Date of Service: 05/15/2010 11:40:03

CLINICAL:
63-year-old male. History of ileus.

X-RAY EXAMINATION: ABDOMEN / PELVIS

TECHNIQUE:
Single AP view of the abdomen / pelvis.

COMPARISON:
None.

FINDINGS:
The visualized lung bases are unremarkable.

There are surgical clips in the right abdomen.

Air distended but not dilated loops of large and small bowel are identified, nonspecific appearance.

There is no demonstrated free abdominal air.

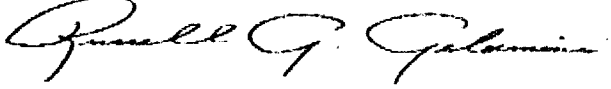
Normal visualized abdominal organs.

The pelvis is unremarkable.

Normal visualized osseous structures.

IMPRESSION:
No demonstrated acute abdominal process.

Signed:



Russell Gelormini, D.O.
May 16th, 2010 at 1:04:09 PM EDT
Electronically Signed

RG/RG

As part of our Quality Assurance Program, we request that surgical or pathologic correlation, or any additional supportive or discordant medical history, laboratory or imaging studies be forwarded to Radisphere National Radiology Group, attention: Peer Review Coordinator. Phone 216.255.5796, Fax 866-788-0204, 23625 Commerce Park, Suite 204 Beachwood, OH 44122.

Physician: [illegible]

Date of Service: 05/15/2010 11:40:03

CLINICAL:
63-year-old male. History of ileus.

X-RAY EXAMINATION: ABDOMEN / PELVIS

TECHNIQUE:
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Air distended but not dilated loops of large and small bowel are identified, nonspecific appearance.

There is no demonstrated free abdominal air.

Normal visualized abdominal organs.

The pelvis is unremarkable.

TRANSMISSION VERIFICATION REPORT

TIME : 05/16/2010 16:16
NAME : TRI STATE
FAX : 4128813522
TEL :
SER.# : BROG8J838359

DATE,TIME	05/16 16:16
FAX NO./NAME	4126617029
DURATION	00:00:25
PAGE(S)	02
RESULT	OK
MODE	STANDARD ECM

PLEASE PRINT

Insurance Requires Your Full Name
Last Name / Middle Initial / First Name

PATIENT NAME Abrams (Last) Shirley (Middle / First)

ADDRESS

CALL REPORTS TO #

NURSING HOME Res. Renal Care

M/CARE # 183287629 A (LETTERS)

MED. ASSISTANCE

OTHER INS. NAME

INS. ID # GROUP #

APPROVAL ❑ YES ❑ NO Approval #

❑ Nursing Home / ❑ Patients Residence

PHONE NUMBER / fx. 661-7029 PHONE NUMBER

SIGN HERE
SIGNATURE PATIENT

TRI-STATE MOBILE X-RAY

PHONE: 412•881•9333
FAX: 412•881•3522
IF NO PHONE SERVICE: 724•746•6099

Prepared by:

D.O.B. 2-28-35 Rm # 212 Unit #

Male ❑ Female ☑

SS# 209-28-12606

RESPONSIBLE PARTY INFORMATION REQUIRED.

Name

Address

City

State Zip

WITNESS'S SIGNATURE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Tri-State Mobile X-Ray, Inc., for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

CHECK ❑ FOR EXAM DESIRED CIRCLE RIGHT OR LEFT			FOR OFFICE USE ONLY VIEWS				CHECK ❑ FOR EXAM DESIRED CIRCLE RIGHT OR LEFT			FOR OFFICE USE ONLY VIEWS		
SPINE:							**EXTREMITIES:**					
❑ LUMBAR			AP	LAT	OBLIQ		❑ SHOULDER	R	L	INT	EXT	OBLIQ
❑ CERVICAL			AP	LAT	OBLIQ		❑ CLAVICLE	R	L	INT	EXT	OBLIQ
❑ DORSAL			AP	LAT	OBLIQ		❑ HUMERUS	R	L	AP	LAT	OBLIQ
❑ COCCYX			AP	LAT	OBLIQ		❑ ELBOW	R	L	AP	LAT	OBLIQ
							❑ FOREARM	R	L	AP	LAT	OBLIQ
THORAX:							❑ WRIST	R	L	AP	LAT	OBLIQ
☑ CHEST			AP	LAT	OBLIQ		❑ HAND	R	L	AP	LAT	OBLIQ
❑ RIBS	R	L	AP	LAT	OBLIQ		❑ FINGERS	R	L	AP	LAT	OBLIQ
❑ STERNUM			AP	LAT	OBLIQ		❑ PELVIS	R	L	AP		
							❑ HIP	R	L	AP	LAT	OBLIQ
ABDOMEN:							❑ FEMUR	R	L	AP	LAT	OBLIQ
❑ PLAIN FILM			AP				❑ KNEE	R	L	AP	LAT	OBLIQ
❑ ABDOMINAL SERIES			AP	LAT	OBLIQ		❑ LOWER LEG	R	L	AP	LAT	OBLIQ
❑ SKULL			AP	LAT	OBLIQ		❑ ANKLE	R	L	AP	LAT	OBLIQ
❑ NASAL BONES			AP	LAT	OBLIQ		❑ FOOT	R	L	AP	LAT	OBLIQ
❑ FACIAL BONES			AP	LAT	OBLIQ		❑ TOES	R	L	AP	LAT	OBLIQ
❑ SINUS			AP	LAT	OBLIQ WATERS							

FACILITY COPY

A Portable Exam is being ordered because, due to age and physical condition, patient is confined to this facility.

❑ HOLTER MONITOR* ❑ EKG HT. WT.

* Lost or damaged equipment will be the responsibility of the patient.

PHYSICIAN'S SIGNATURE

FIRST NAME LAST NAME Khan

ADDRESS

PHONE

Symptoms of Patient (Dr. ordering exam please initial)

flu

Does the patient have reason to believe she is pregnant? ❑ Yes ❑ No

Protective Shielding Used? ❑ Yes ❑ No

Date Completed

Technician 5-17-10

TRI-STATE MOBILE X-RAY
4684 CLAIRTON BOULEVARD
PITTSBURGH, PA 15236
(412) 881-9333

Name:	Abrams Shirley
Patient ID:	121-209281266
History:	Chest: congestion
Date of Birth:	02/28/1935
Study:	RG - Chest, PF Chest
Facility:	Residence Renal Care
Physician:	Khan, Dr.
Date of Service:	05/17/2010 17:11:00

CLINICAL:
congestion

X-RAY EXAMINATION - CHEST

TECHNIQUE:
Single frontal view of the chest.

COMPARISON:
None.

FINDINGS:
The view is apical lordotic.
The exam is limited by motion artifact. There is a tracheostomy tube in place. The heart is normal in size. There is pulmonary edema. There may be a small left pleural effusion. The bones are osteopenic.

IMPRESSION:
There is pulmonary edema.

Signed:

Julia Lee, M.D.
May 17th, 2010 at 9:10:09 PM EDT
Electronically Signed

JL/JL

As part of our Quality Assurance Program, we request that surgical or pathologic correlation, or any additional supportive or discordant medical history, laboratory or imaging studies be forwarded to Radisphere National Radiology Group, attention: Peer Review Coordinator. Phone 216.255.5796, Fax 866-788-0204, 23625 Commerce Park, Suite 204 Beachwood, OH 44122.

Radiological Interpretation Provided by Apex Radiology, Inc., Coral Springs, Florida